Nursing Facility Forum Call February 5, 2015

Case Mix Team

Office of MaineCare Services

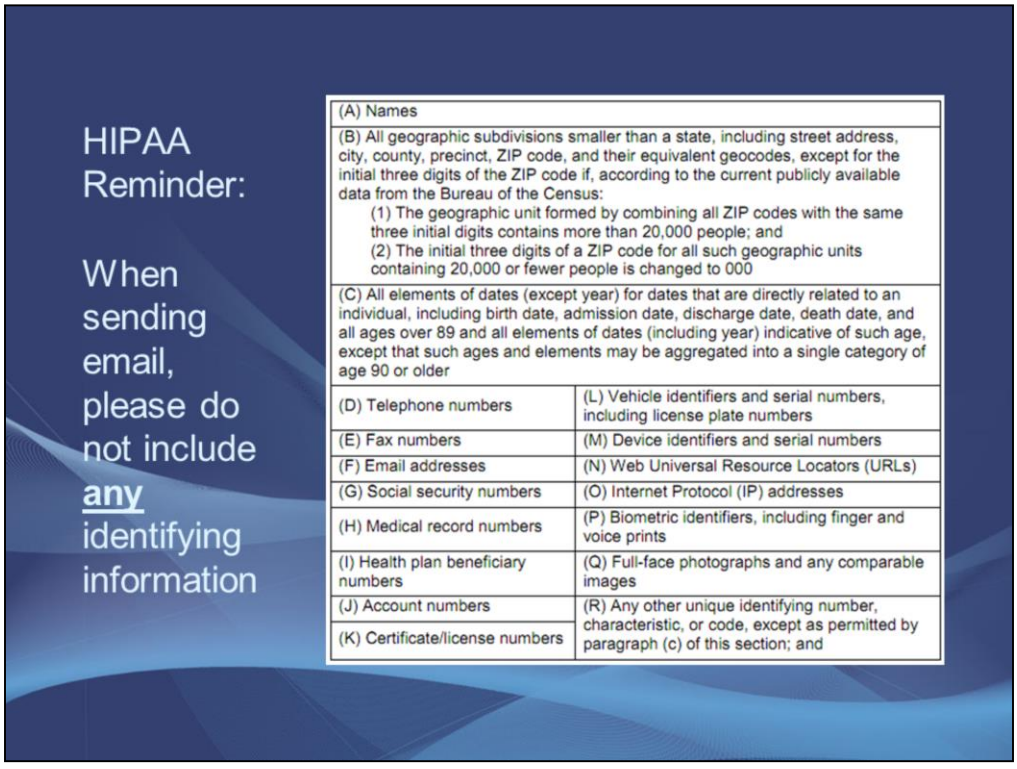
Agenda

- Welcome
- HIPAA Reminder
- Review of Questions/Answers for MDS 3.0
- Section S issue
- Snippet Training: Medicare Part B Therapy
- Questions
- Announcements

Welcome to the Winter web-based forum call!

In the lower right hand corner of the screen, you will see a box called "files." These are documents that can be downloaded, and they will also be sent out via email.

There is a Q + A box where you can type in questions if you would prefer to submit a written question rather than ask a question



Protected Health Information (PHI)

Information in any format that identifies the individual, including demographic information collected from an individual that can reasonably be used to identify the individual. Additionally, PHI is information created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual.

De-identified

Information that has certain identifiers (see “identifiers” below) removed in accordance with 45 CFR 164.514; no longer considered to be Protected Health Information.

(Note: Please be aware that individual participants may be identifiable by combing other items in the data een when none of the following 18 identifiers are present. Thus, a study may still contain personally identifiable data (PID) even after removing or never acquiring the identifiers listed below, and the investigator may still need to provide complete answers for the data security questions (Items 8-10) in the protocol.)

Identifiers

Under the HIPAA Privacy Rule “identifiers” include the following: 1. Names

2. Geographic subdivisions smaller than a state (except the first three digits of a zip code if the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people and the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000).

3. All elements of dates (except year) for dates directly related to an individual, including birth date,admission date, discharge date, and date of death and all ages over 89 and all elements of dates (including year) indicative of such age (except that such ages and elements may be aggregated intoa single category of age 90 or older)

4. Telephone numbers

5. Fax numbers

6. Electronic mail addresses

7. Social security numbers

8. Medical record numbers

9. Health plan beneficiary numbers

10. Account numbers

11. Certificate/license numbers

12. Vehicle identifiers and serial numbers, including license plate numbers

13. Device identifiers and serial numbers

14. Web Universal Resource Locators (URLs)

15. Internet Protocol (IP) address numbers

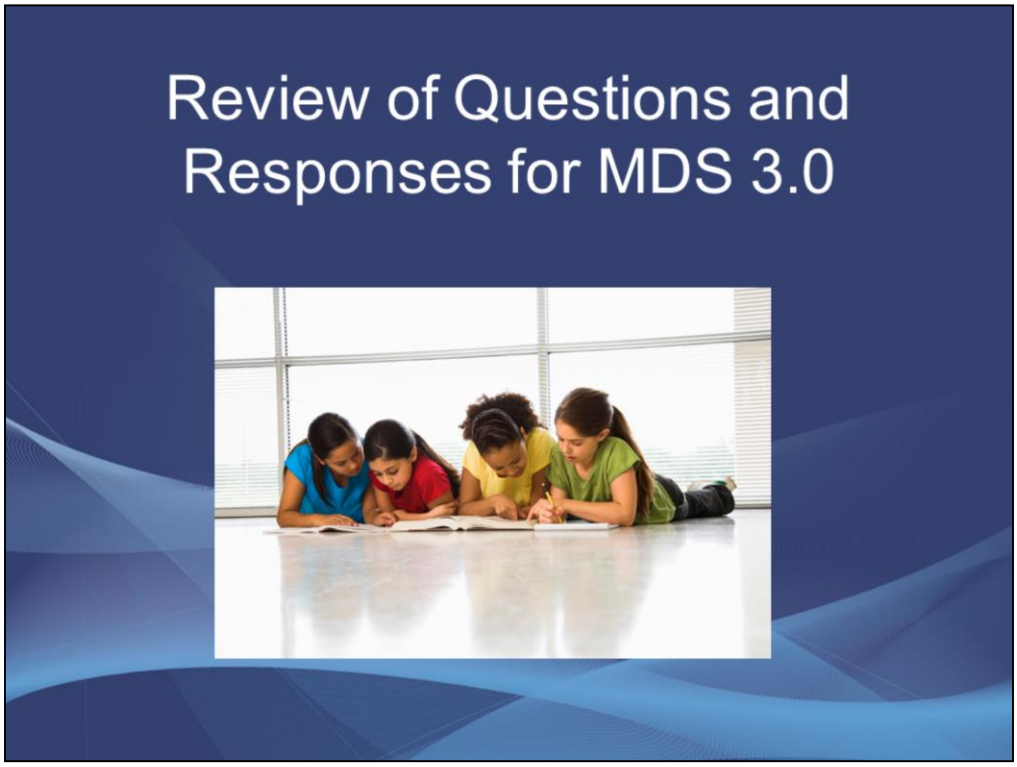
16. Biometric identifiers, including finger and voice prints

17. Full face photographic images and any comparable images

18. Any other unique identifying number, characteristic, or code (excluding a random identifier code for the subject that is not related to or derived from any existing identifier

For more information:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html



While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

Chapter 2:

A Long term care VA resident has been getting OT for many months.

9/9: quarterly OBRA, RUG = RMC

10/9: significant change to initiate Hospice; RUG = RMC

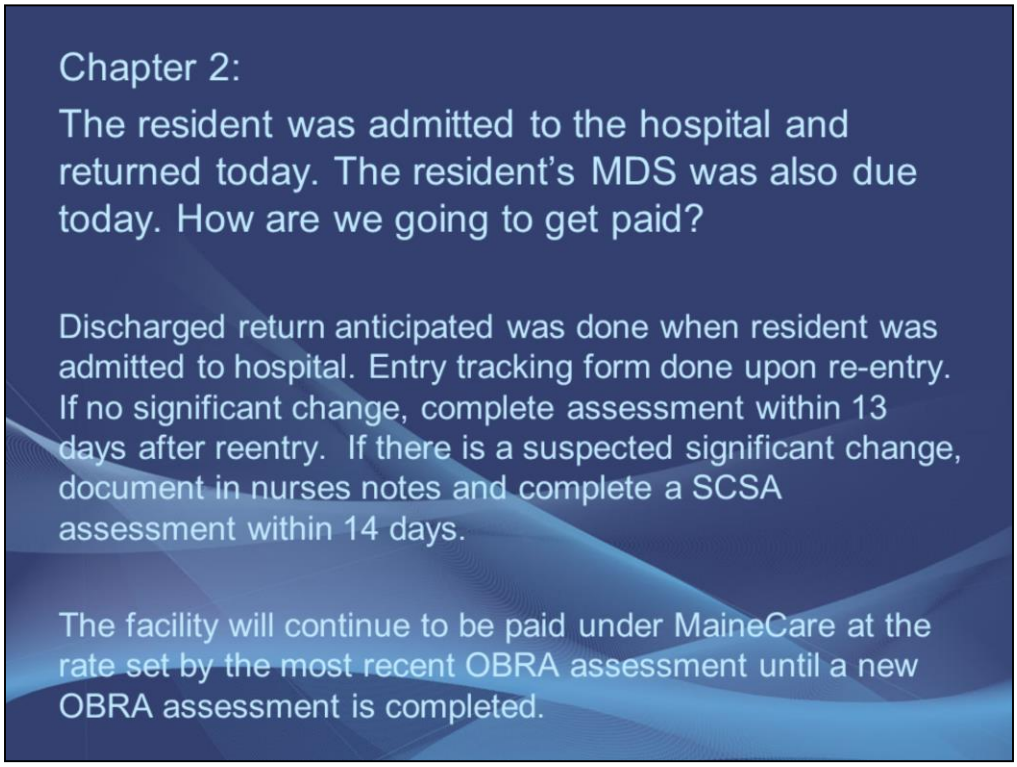
10/10: OT discontinued, no assessment was done

VA is requesting that an EOT be completed so they don't have to pay the RMC rate any longer.

Response:

If VA is the payer, they can instruct the facility which assessments to complete in order to determine the payment rate. Assessments completed at the request of the VA are not submitted through the ASAP system.

MDS is based on the resident. For a resident with VA as the primary payer, the facility is required to submit OBRA assessments only.



For additional information, see the document posted to the HealthPAS portal in September 2010 that describes RUGs, assessment dates/schedules, and billing cycles.

RAI Manual page 2-36: "If a SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment)."

Chapter 2:

A resident was admitted to the facility and sent to the ER 6 hours after admission.

Resident was at the hospital overnight, in "observation" status. The resident returned to the facility in the morning.

How will the facility get paid for the day of admission and what assessments need to be completed?

Leave of Absence (LOA), which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:

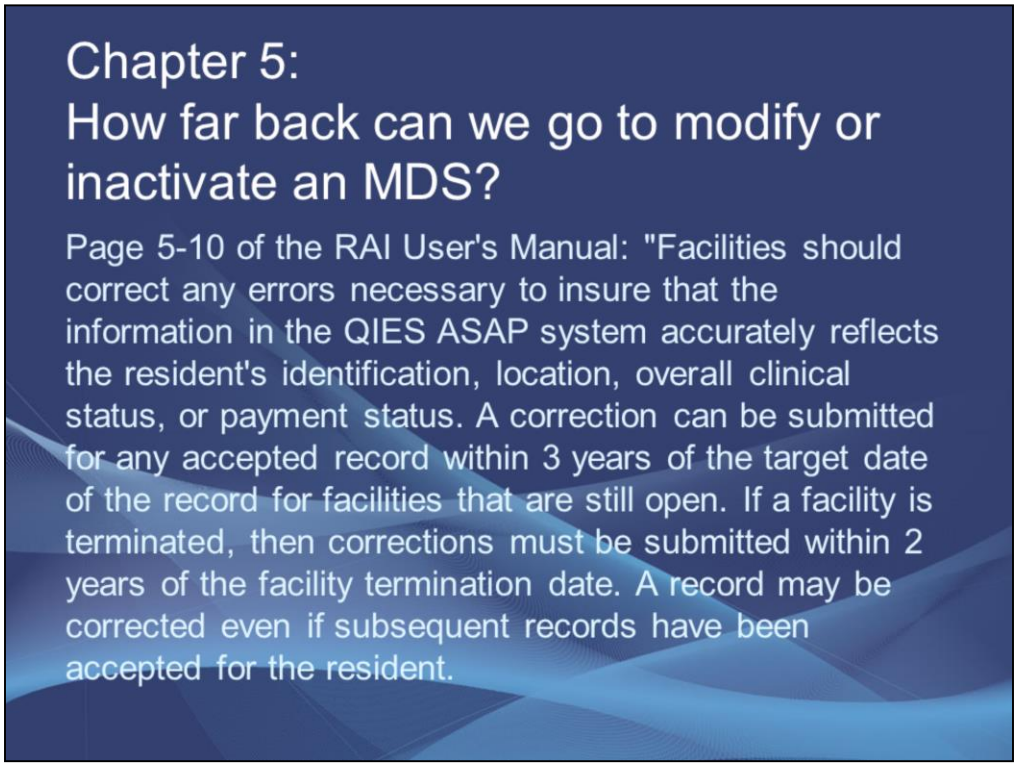
- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the patient.

Upon return, providers should make appropriate documentation in the medical record regarding any changes in the resident. If there are changes noted, they should be documented in the medical record. (RAI page 2-12)

If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-12 in this chapter, the Medicare assessment schedule may be adjusted for certain assessments. For **scheduled PPS assessments,** the Medicare assessment schedule is adjusted to exclude the LOA when determining the appropriate ARD for a given assessment. For example, if a resident leaves a SNF at 6:00pm on Wednesday, which is Day 27 of the resident's stay and returns to the SNF on Thursday at 9:00am, then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay. Therefore, a facility that would choose Day 27 for the ARD of their 30- day assessment would select Thursday as the ARD date rather than Wednesday, as Wednesday is no longer a billable Medicare Part A day. (RAI page 2-74)

In the example given, the date of admission remains the same for MDS purposes, but is considered to be a leave day as the resident was not in the facility at midnight.

The facility may not be able to bill for that day as it is considered to be a leave day.



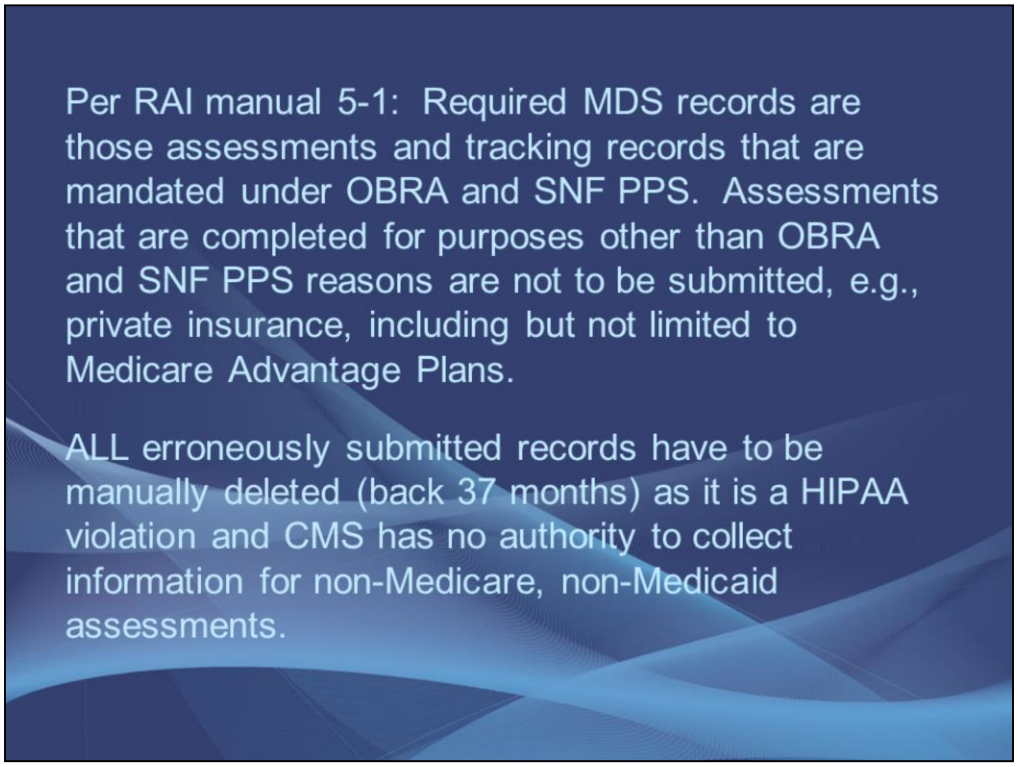
This is from page 5-10 of the RAI User's Manual: "Facilities should correct any errors necessary to insure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record within 3 years of the target date of the record for facilities that are still open. If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date. A record may be corrected even if subsequent records have been accepted for the resident.

"Errors identified in QIES ASAP system records must be corrected within 14 days after identifying the errors."

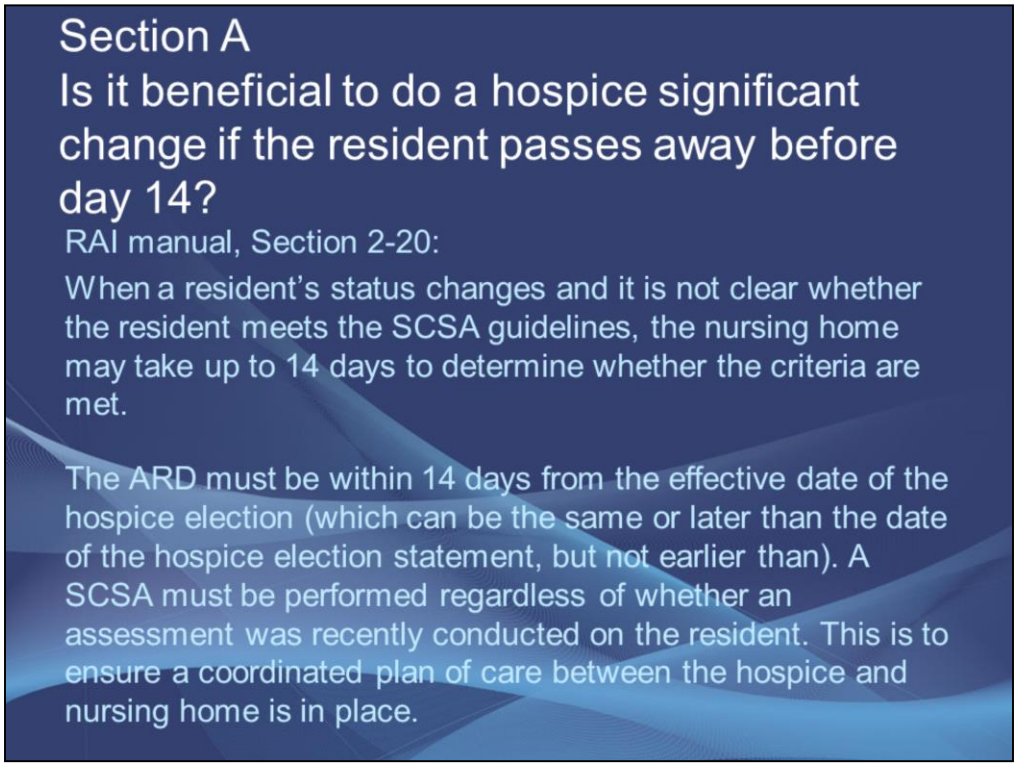
• Target Date

- Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1)
- Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12),
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.*

Chapter 5:
Non-Medicare, non-OBRA assessments (5-day) have been submitted to CMS in error and deletions need to be done, but how far back?



37 months = current month plus 36 month



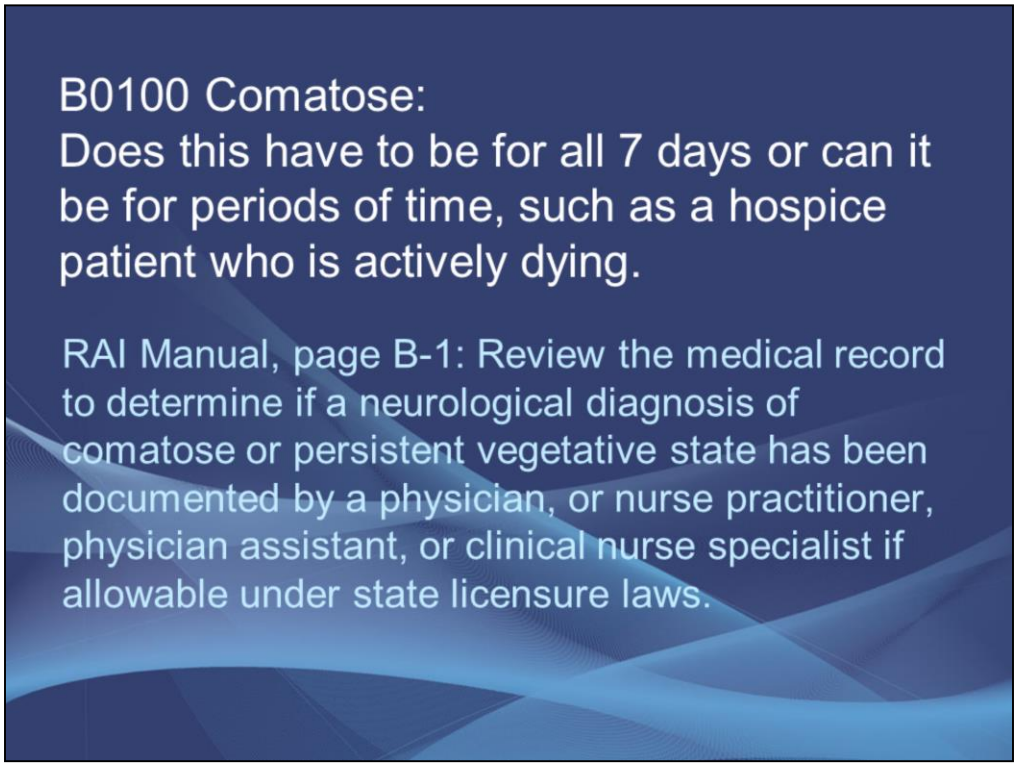
RAI manual, Section A-5:

If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS significant change in status assessment (SCSA). The nursing home is required to complete a SCSA when they come off the hospice benefit (revoke). See Chapter 2 for details on this requirement.

It is a CMS requirement to have a SCSA completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit.

This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.

The assessment must be completed by day 14, but can be completed earlier. It may be beneficial to complete the assessment.



Code 0, no: if a diagnosis of coma or persistent vegetative state is not present during the 7-day look-back period.

If there IS a diagnosis of comatose or persistent vegetative state, than you can code for item B0100.

Section I

Physician documented “paraparesis.” How is this coded on the MDS?

I4900 = hemiplegia or hemiparesis (paralysis or weakness on right or left side)

I5000 = paraplegia (paralysis, not weakness of lower extremities)

I5100 = quadriplegia (paralysis of all four limbs)

If resident has weakness of lower extremities, code under I8000. Facility may choose to clarify accuracy of diagnosis with physician if this is not correct.

Section M

The facility coded an ulcer on a resident's heel as a pressure ulcer. The MD examined the resident and documented the ulcer as a vascular ulcer. How can the facility change coding of the pressure ulcer to a vascular ulcer when the wound did not heal or become worse?

Response:

Write a nurse's note referencing the physician's note that indicated the ulcer was coded in error as pressure and submit a modification to the MDS.

Regarding M1200B, pressure reducing device for the bed. The device being used is not an air loss mattress, but it is rated for stage 2 pressure ulcers. Would this be coded under M1200B?

Response: Yes, it is a pressure reducing device.

Section N
Can Melatonin be coded as a hypnotic in Section N?

Regarding N0410, the instructions on N-6 in chapter 3 are very clear and apply to all facilities: "Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used.

For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic."

Section O – Restorative Nursing

Resident's spouse has been trained to perform ROM and chooses to provide ROM to resident one time per day in addition to ROM provided by restorative aide. Can facility code for ROM provided by spouse?

Facility can code only for care provided by facility staff.

RAI manual O-38: O0500, under Technique; "activities provided by restorative nursing staff." Under Training and Skill Practice, "… provided by any staff member under the supervision of a licensed nurse."

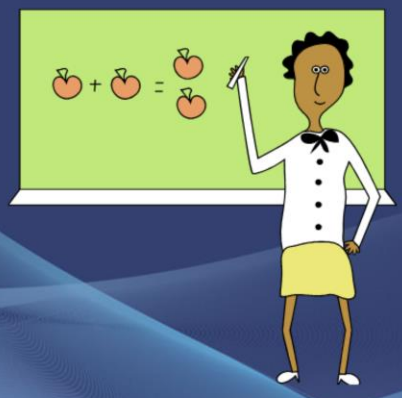
Section S:
Not all PPS assessments show up on the State's roster as a PPS assessment

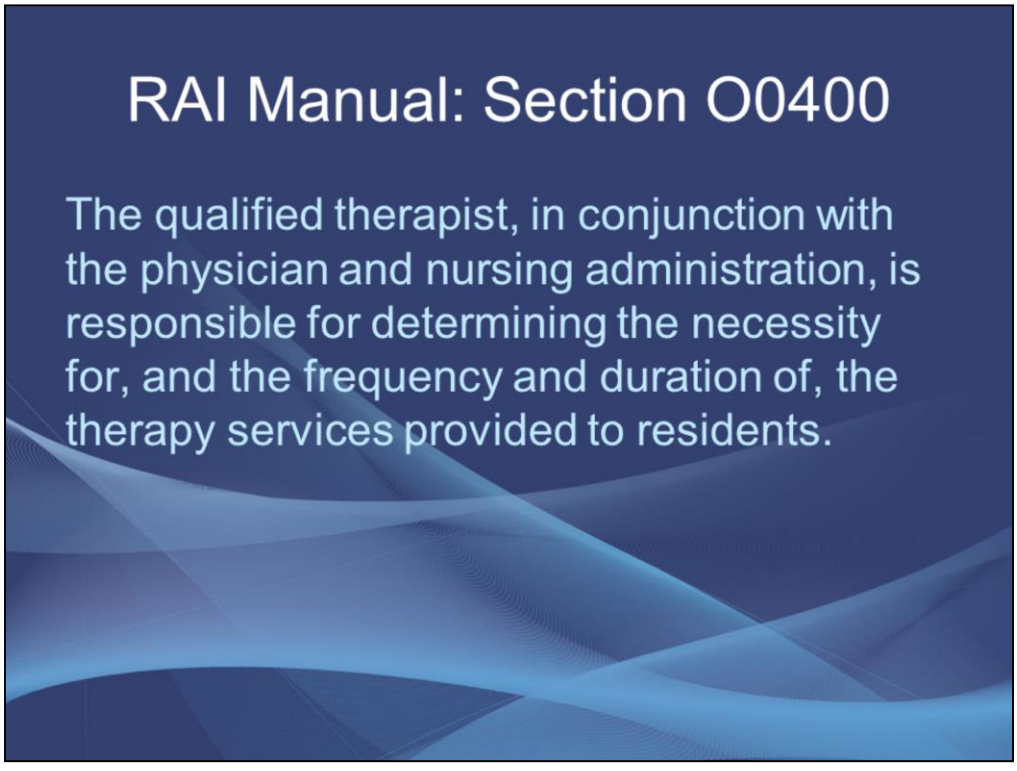
When an assessment is completed for a resident receiving Medicare A services PPS, code A310A according to the OBRA reason for assessment, code A0310B according to the type of PPS assessment (5, 14, 30 etc.).

In Section S8010, code C3, MaineCare as per diem payer if the resident has MaineCare only. Code G3 if the resident has MaineCare to cover the co-pay AND the ARD date is past day 20 of the resident's stay. Medicare covers at 100% for the first 20 days.

Snippet Training

Medicare Part B
Therapy

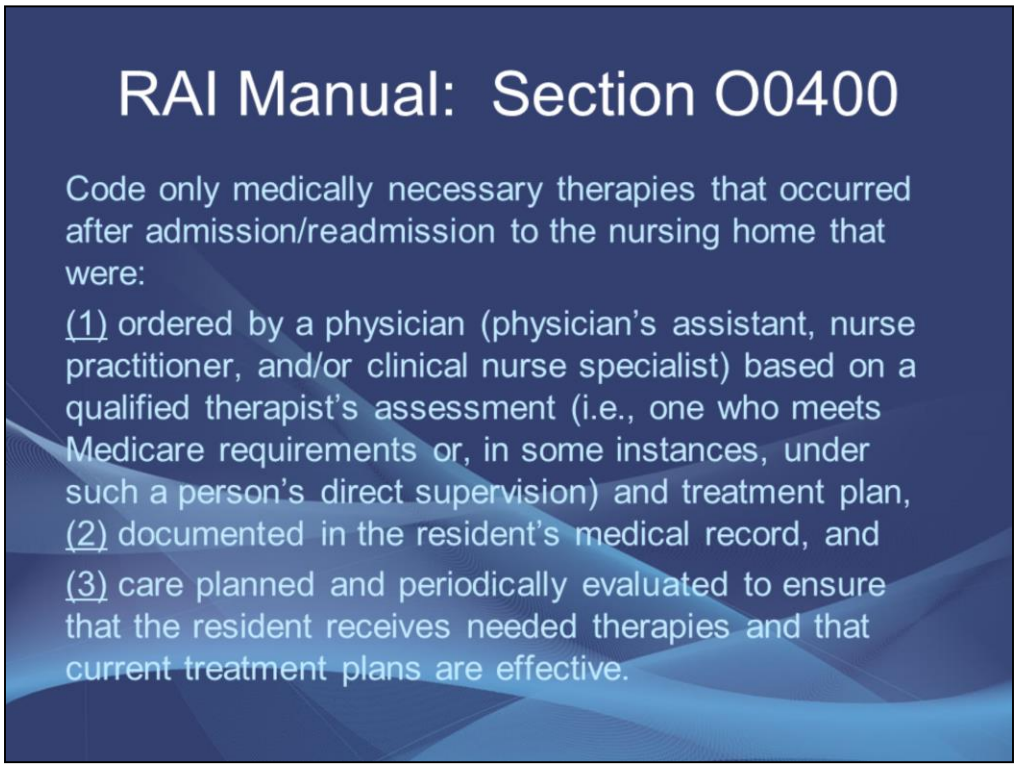




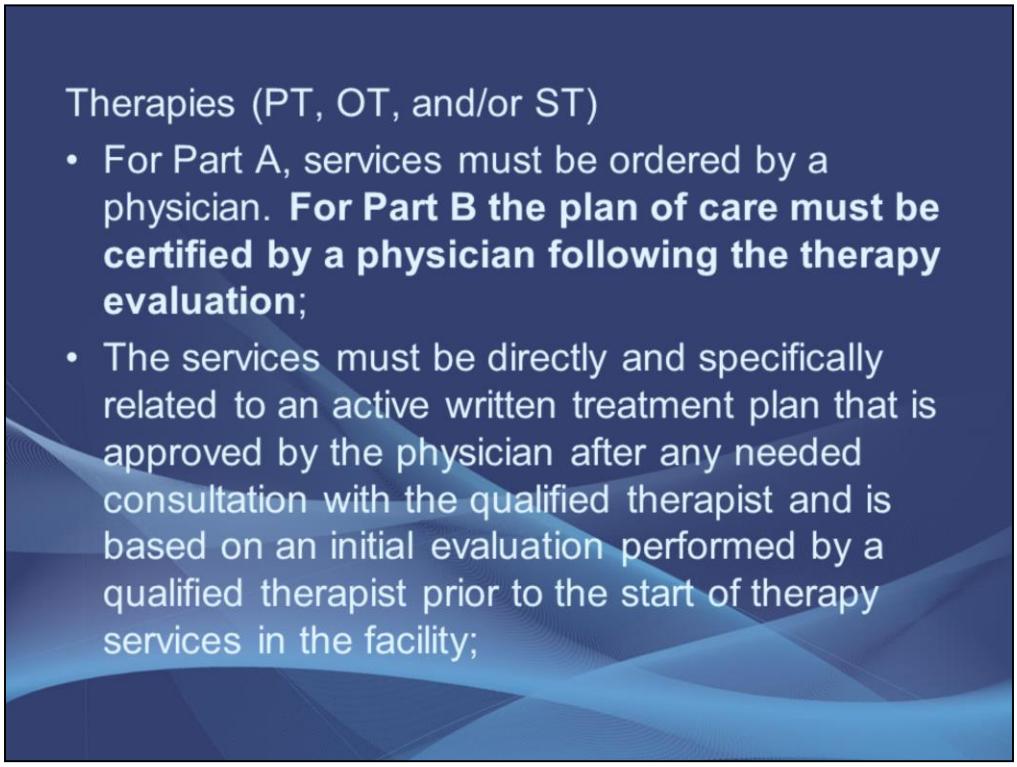
Page O-16

Item Rationale

Health-related Quality of Life



O-17: Planning for Care



RAI Manual, page O-20 and O-21

The therapist's time spent on documentation or on initial evaluation is not included.

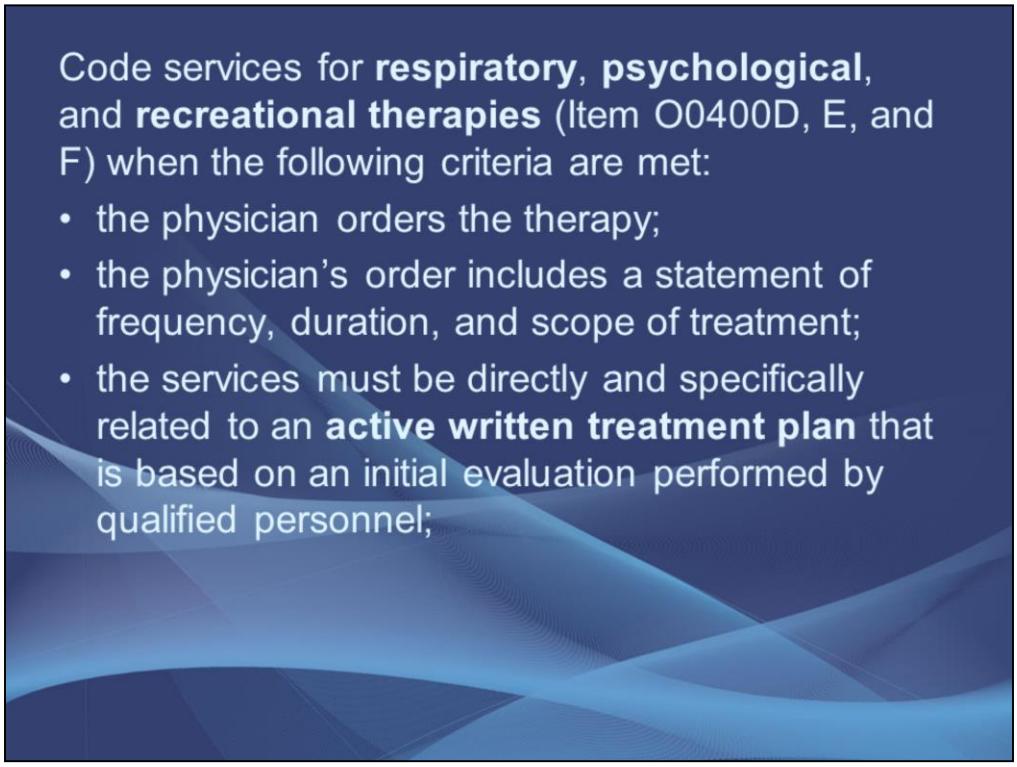
Family education when the resident is present is counted and must be documented in the resident's record.

Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS.

The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.

- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A.

- Please note that therapy logs are not an MDS requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.



the services are required and provided by qualified personnel;

the services must be reasonable and necessary for treatment of the resident's condition.

MaineCare Benefits Manual

Chapter I:

Section 1: General Administrative Policies and Procedures

Chapter II:

Section 67: Nursing Facility Services

Section 68: Occupational Therapy Services

Section 85: Physical Therapy Services

Section 109: Speech and Hearing Services

Chapter I, Section 1

Section 1.03-3 Requirements of Provider Participation

Enrolled providers must:

R. Comply with requirements of applicable Federal and State law, and with the provisions of this manual

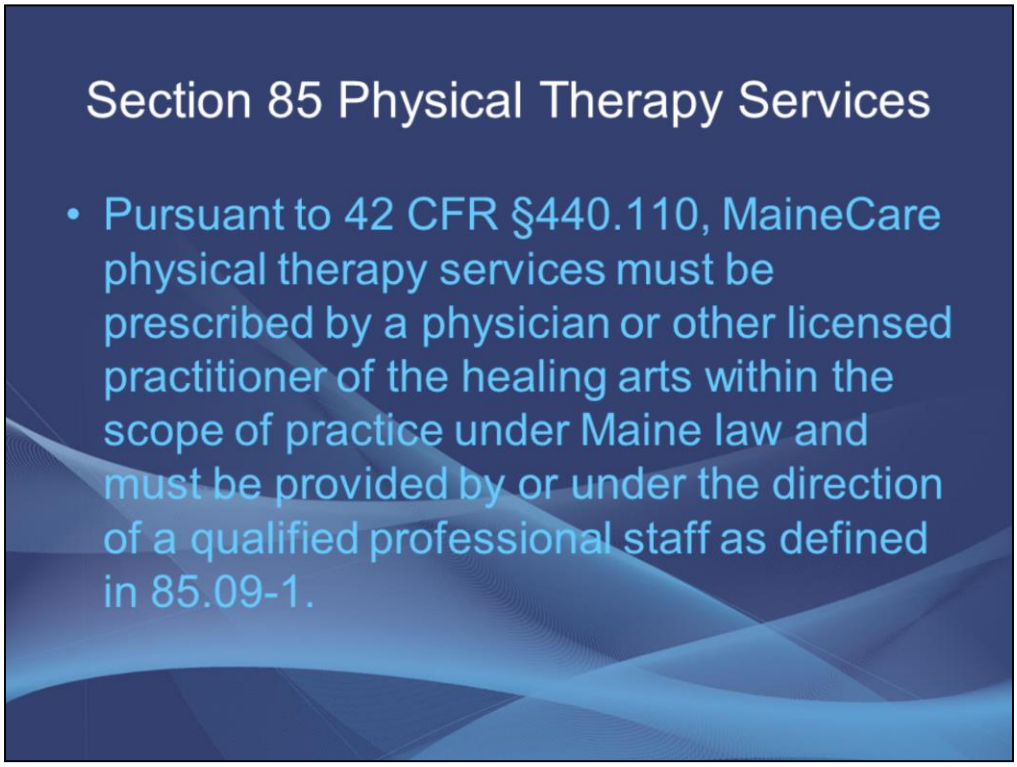
1.19-1 Grounds for Sanctioning and/or Recouping MaineCare payments from Providers, Individuals or Entities

The Department may impose sanctions and/or recoup identified overpayments against a provider, individual, or entity for any one or more of the following reasons:

G. Breaching the terms of the MaineCare Provider Agreement …

Section 67

Section 67.02-3.A.8: The findings of an initial evaluation and periodic reassessments must be documented in the person's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.



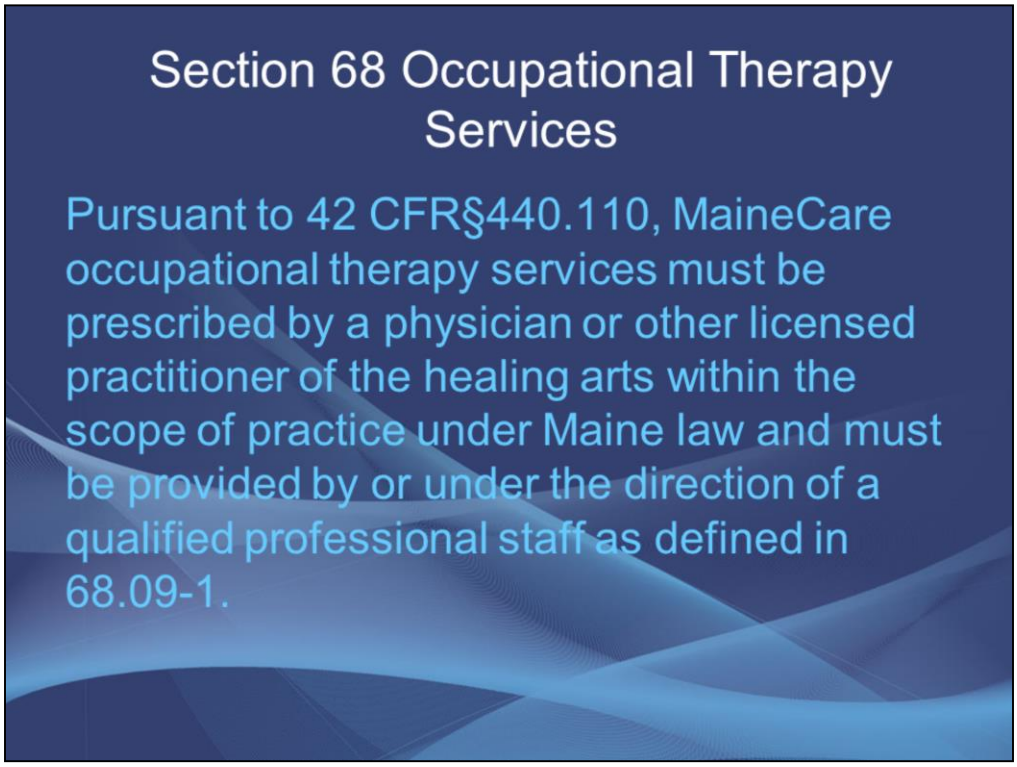
Chapter II, Section 85.06, Covered Services

42 CFR § 440.110

§ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders. (a) *Physical therapy.*

(1) *Physical therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A "qualified physical therapist" is an individual who meets personnel qualifications for a physical therapist at § 484.4.



Chapter II, Section 68.06

(b) *Occupational therapy.*

(1) *Occupational therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A “qualified occupational therapist” is an individual who meets personnel qualifications for an occupational therapist at § 484.4.

42 CFR § 440.110

§ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(b) *Occupational therapy.*

(1) *Occupational therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

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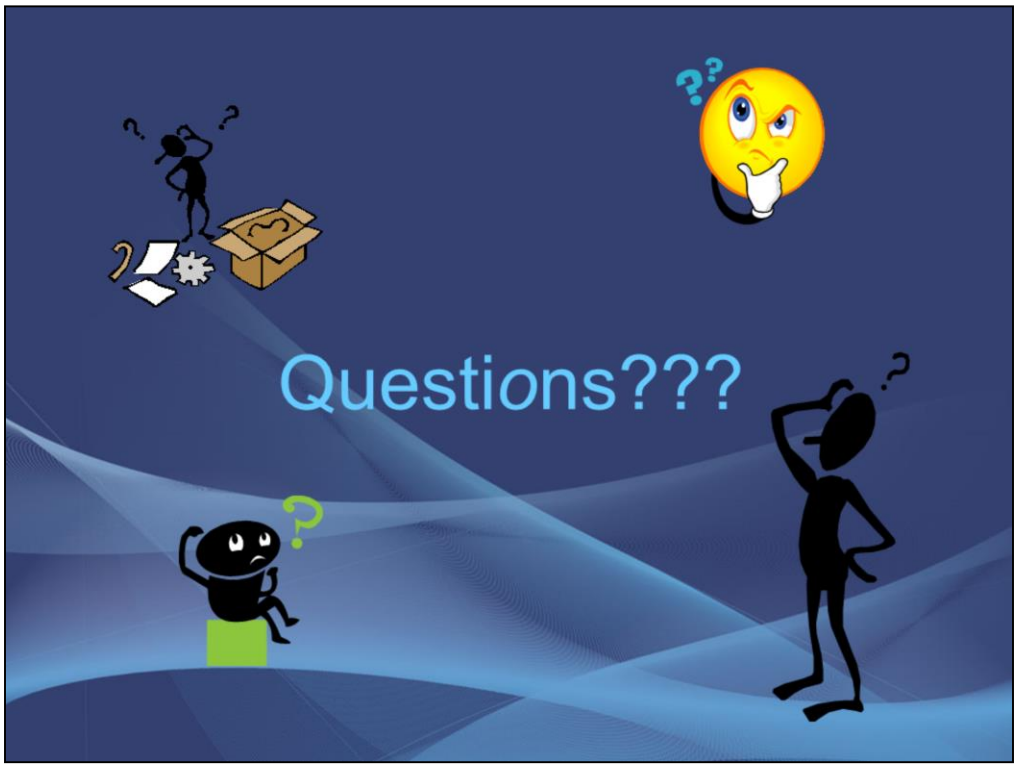
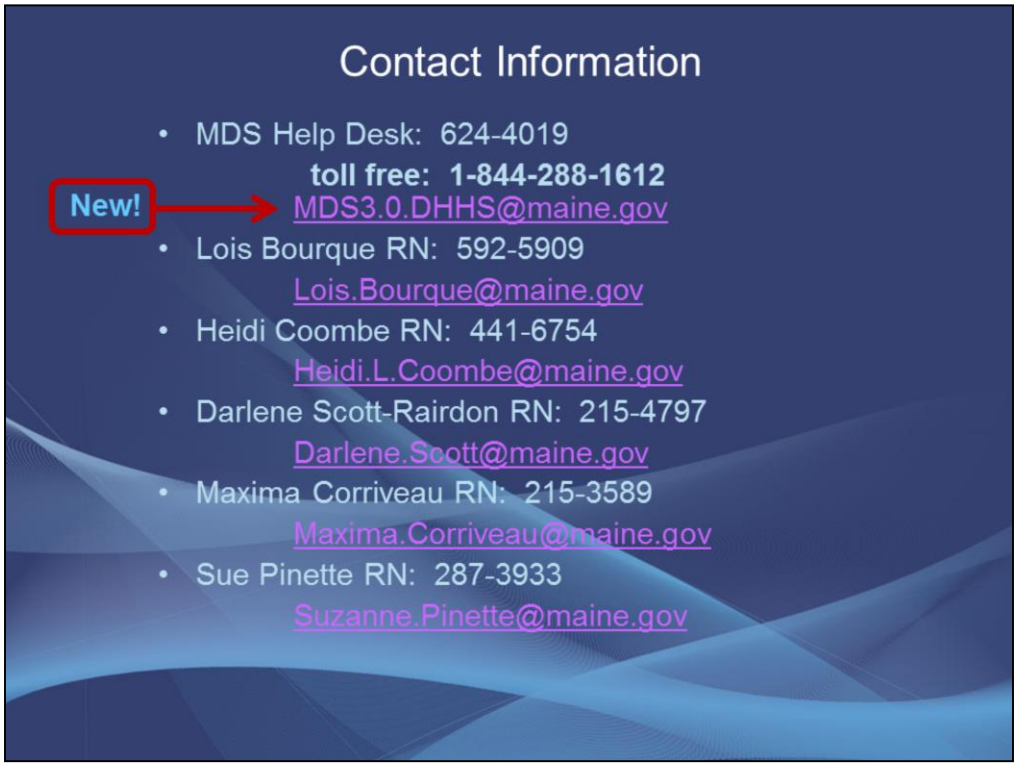

Questions???

Announcements and Reminders:

- New Toll Free Help Desk number:
  1-844-288-1612
- Please do NOT send protected health information (PHI) via email unless the email is encrypted.
- Upcoming MDS 3.0 Training:
  2/20/15 Augusta
  4/9/15 Bangor
- Next call: May 7, 2015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MDS Help Desk: 624-4019
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